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ABSTRACT

A 12-month outcome study was conducted on 129 patients discharged from a hospital-based substance abuse treatment program in an effort to identify the progress of patients after treatment, evaluate the treatment program, and improve the program based on the evaluation. Subjects completed two demographic questionnaires and a 12-month post-discharge patient follow-up questionnaire. The results indicated that the treatment approaches used were effective in providing a high rate of abstinence (between 53% and 86%) and improved self-perceived quality of life. Alcoholics Anonymous attendance, family/significant other involvement, and outpatient follow-up treatment participation were consistent predictors of abstinence. Several groups of patients were found to have benefited less from treatment than others: women, persons younger than age 40 or older than age 60, persons with concomitant psychiatric diagnoses, and persons without marital stability. These findings suggest the need for treatment changes and further research, which are now being implemented. (Author/NB)

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Substance Abuse:

A 12-Month Outcome Study Following Inpatient Treatment

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Abstract

A 12-month outcome study was conducted on 210 patients discharged from a hospital-based substance abuse treatment program in order to evaluate and improve treatment methods. Treatment approaches were effective in providing a high rate of abstinence (between 53% and 86%) and improved self-perceived quality of life. AA attendance, family/significant other involvement, and outpatient follow-up treatment participation were consistent predictors of abstinence. Several groups of patients benefitted less from treatment than others. Based on these findings, treatment changes and further research were recommended and are currently being implemented. The impact of clinical outcome research in consultation with corporations is discussed.

Substance Abuse:

A 12-Month Outcome Study Following Inpatient Treatment

Substance abuse treatment has largely developed from self-help and para-professional approaches because for decades medical and mental health professionals were frustrated and relatively ineffective in treating this population. Numerous substance abuse treatment corporations have been formed since the early 1970s; and a relatively standardized inpatient treatment approach has evolved based on experience, perceived successful strategies, and a minimal amount of focused research.

The substance abuse treatment field has now evolved substantially; and it is time to examine folklore and carefully refine treatment approaches, based on research findings and clinical knowledge, so they are maximally helpful to the specific populations being served. Perhaps not all substance abusers need the same "canned" treatment package. It is imperative that psychologists, working with treatment corporations, investigate and evaluate the inpatient treatment of substance abuse with the aim of scientifically improving the quality and outcome of treatment.

The present study, conducted in consultation with a large substance abuse treatment corporation based in California, was designed to identify the progress of patients after treatment, to evaluate the treatment program, and to improve the program based on this evaluation. In addition, it was anticipated that the follow-up process itself would increase patient involvement in a continuing recovery support network, by means of providing ongoing contact with the staff and by stimulating patients' thinking about their recovery processes.

This follow-up study investigated outcome regarding substance use and self-perceived quality of life one year after discharge from an inpatient treatment program. Questions asked included:

1. What predicts decreased substance use?

2. Is this different for men and women, for older and younger people, for alcoholics versus polysubstance users?

3. Is there a relationship between self-perceived quality of life and abstinence?

4. Is there a difference between current quality of life and that before treatment?

5. Are there particular areas that seem to be going well for patients and others that are not (i.e. family relations, peer relations, work, finances)?

6. Are we more effectively intervening in the disease process for some groups of patients than for others? If so, what implications does this have for program changes?

Method

Participants

Participants in this study included all patients discharged from an inpatient substance abuse treatment program in Northern California, between January, 1982, and December, 1982. The total sample was 210 patients who completed treatment and were currently alive at the time of follow-up. Of these potential participants, 129 (61%) provided information for the 12-month post-discharge follow-up questionnaire. Sixteen (8%) directly refused to participate, and 65 (31%) had changed addresses, phones, and work places so were unable to be located.

Of the 129 participants, 87 (67%) were male and 42 (33%) were female. The mean age was 51 years, and the median age was 48 years. The average length of stay on the inpatient unit was 28 days. Ninety-seven percent of the participants were caucasian.

A comparison on major demographic characteristics was made between those participants who filled out the follow-up questionnaire and those patients for whom there was only the demographic data form, in order to ascertain how the nonparticipants were different from the participants.

Procedure

Instruments used included two demographic data forms and a 12-month post-discharge patient follow-up questionnaire. The patient follow-up questionnaire was designed by the researcher to elicit self-report data regarding substance use since treatment; AA attendance, and self-perceived quality of life before treatment, immediately after treatment, and currently. In addition, qualitative questions and suggestions for changing treatment were asked.

Demographic data forms were completed by case managers and secretaries based on information collected during the assessment phase of treatment. A follow-up questionnaire was mailed to each patient at 12-months post-discharge. Return-addressed, post-paid envelopes were provided. When the form was not returned within two weeks' time, secretaries made repeated phone calls to obtain the questionnaire information. The objective was to gather all data within one month after each mailing, and records were kept regarding all attempts and responses. The data was collected over a one-year period, during 1983.

In addition to descriptive statistics and simple comparisons between groups, logistic regression analyses were used to predict substance use since treatment.

Results

Overall, the treatment of substance abuse was successful: 86% of the participants were abstaining at 12-months post-discharge. However, there was no substance use data for 37% of the potential participants, because they did not return the follow-up questionnaires. Therefore, the actual percentage of patients abstaining at 12-months post-discharge fell somewhere between 53% and 86%. In

addition, the longest period of abstinence since treatment was significantly greater than that before treatment for the participants (Binomial Sign Test, $p \leq .0001$). The longest abstinence before treatment was one month or less for 69% of the participants, whereas the longest abstinence since treatment was six months or longer for 72% of the participants.

There were several variables that consistently predicted abstinence: full family or significant other involvement during the inpatient phase of treatment, more frequent AA attendance, and higher number of times that patients attended aftercare (the outpatient group treatment program following inpatient treatment). High frequency of AA attendance was particularly important for female patients and for older patients ($\geq$ age 40). It was not possible to meaningfully consider the difference between alcoholics versus polysubstance users due to a small sample of polysubstance users.

Insert Table 1 about here

There was no relationship between self-perceived quality of life and abstinence. However, participants perceived their lives as better on the whole one year after treatment than before treatment, regardless of continued substance use or abstinence (mean difference 1.56 on a seven-point scale, $t = 15.06$, $p \leq .0001$). In addition, there were no specific areas of relationships and life (i.e. family relations, peer relations, work, finances) that were perceived to be going better or worse than other areas.

Female patients and patients younger than age 40 were more likely to use substances within one year after treatment than male patients and older patients. In addition, patients over age 60 were more likely to use than those ages 40 to 60, though those under age 40 were most likely to use. Two other groups of patients

also appeared to do less well with treatment based on their nonparticipation in the follow-up questionnaire: those who had concomitant psychiatric diagnoses and those without marital stability (the single, separated, and widowed versus the married and divorced).

Insert Table 2 about here

Conclusions

Overall, current inpatient treatment approaches for substance abuse were effective in providing a high rate of abstinence and improved self-perceived quality of life. Family involvement, AA attendance, and aftercare attendance need to be strongly supported and emphasized to patients since these were the variables that consistently predicted abstinence. In addition, family and aftercare treatment components could be beneficially expanded and strengthened since they are crucial to abstinence.

Several groups of patients were apparently not being treated as effectively as the others: women, those younger than age 40, those older than age 60, those with concomitant psychiatric diagnoses, and those without marital stability. Women may need more specialized treatment approaches than currently provided, including more all-women groups. Younger patients may need a separate, more long-term, habilitative treatment approach (much as adolescents do). Older patients may also need more specialized treatment approaches based on their developmental needs and cognitive capacities. For patients with concomitant psychiatric diagnoses, potential treatment improvements could include more judiciously utilizing psychological and psychiatric consultation, referral to additional resources, more education of staff regarding differential diagnosis and treatment, and more individualized treatment plans. For those with marital

instability, approaches could include helping them build more networking and emphasizing codependent rather than "family" treatment.

This study was most limited by the response rate (61%) and by the type of data gathered. It was not possible to draw adequate conclusions about patients who continue to relapse after treatment because few participated in the study. Self-report data is fraught with social demand characteristics aided by psychological defenses of denial, minimization, and rationalization. People want to look good and therefore may not be honest with themselves or with researchers. Conducting a longitudinal study with corroborative data from codependents could help alleviate both major limitations of the present study.

Conducting similar studies at other hospitals/treatment programs would provide a comparison of results in order to ascertain whether results were unique to these patients and program or whether general trends were being found. In addition, combining data on polysubstance and drug users from several treatment programs could provide an adequate sample size for statistical comparisons.

Future more specific studies could be designed to study various aspects of treatment including codependent treatment, aftercare, treatment of women, treatment of younger and of older patients, treatment of patients with concomitant psychiatric and/or medical diagnoses, and a focused study of relapse.

The present study has had an impact on the consulted substance abuse treatment corporation in terms of both continued research and provision of treatment. Three similar studies are currently being conducted, two in inpatient and one in outpatient programs. A more costly two-year longitudinal study with corroborative codependent data is also in process. A focused study on relapse is being designed. Treatment is being reconsidered, refined, and strengthened

for codependents, aftercare, women, younger people, and patients with dual diagnoses. It will be interesting to ascertain how these program changes will influence future outcome studies. Clinical outcome research within corporations can impact the policies and quality of substance abuse treatment.

Table 1

Logistic Regression Procedure for All Participants Combined

Variable	Beta	Chi-square	p Level
Sex of patient	1.25620654	4.75	0.03*
Employment status before treatment	0.37385716	2.06	0.15
Education	0.14117985	0.39	0.53
Family/significant other involvement in inpatient treatment	-1.06326379	4.01	0.05*
Frequency of AA attendance	-0.32463144	6.86	0.01*
Number of weeks patient attended aftercare	-0.00228882	0	0.96
Number of times patient attended aftercare	-0.12655767	4.16	0.04*
Number of times family/significant other attended aftercare	0.03012321	0.02	0.88

* = statistically significant

Table 2

Plot of Outcome Versus Age

Some substance use since treatment N = 66	22	27	17	
No substance use since treatment N = 63	6	40	17	
	19	40	60	78 Age